

Correspondence

We try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in a bimonthly journal where continuity of comment and redress are difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Training for Rural Emergency Care

To the Editor: I read with interest the survey report by Hall and Nowels (Hall WL, Nowels D. Colorado family practice graduates' preparation for and practice of emergency medicine. *J Am Board Fam Pract* 2000;13:246-50), and wish to confirm their findings on the basis of our own 10-year experience in training family practice residents for comprehensive primary care in a rural environment that frequently involves providing emergency service.

At our rural demonstration site, our faculty staff the emergency department of the local hospital and see 18,000 undifferentiated seekers of acute, urgent, and emergent care yearly. We provide first-hour care in trauma, adult medicine, pediatrics, surgery, women's health care, and behavioral medicine. Faculty from our three sites (University Medical Center, Suburban, and Rural) contribute an average of one to two shifts per month, which refreshes their urgent care skills. Residents from these three sites spend time in the emergency department during their emergency medicine rotations, and students spend part of their required 2-month rotation in family medicine in the emergency department seeing family physicians providing critical care, an important role-modeling aspect of our training credo. We also have a 12-month fellowship in emergency medicine for family physicians entering areas of practice where additional skills are needed. Our fellows rotate as part of their training at the University Trauma Center.

Our department provides advanced trauma life support training for all faculty, fellows, and residents. Our rural location requires us to provide fracture, laceration, burn, and other wound management not often dealt with in the typical family practice training program. The advantages of such an arrangement for rural underserved areas are that the training empowers the residents with a sense of capability, and our graduates do not generally suffer from the feeling of "trained impairment" often encountered after rotations at the academic centers. Part of the duties of service in a rural environment necessitates contact with the emergency medical system, including prehospital radio contact as well as elbow contact in the emergency department, where the emergency medical technicians train as well as frequently assist in patient

care. Residents and fellows often ride on the ambulances to view urgent care first hand in rural areas. Postfellowship recognition is available through the American Academy of Physicians and Surgeons Board of Certification in Emergency Medicine for board-certified family physicians and a special track is offered to fellowship graduates.

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Cancer Screening Rates

To the Editor: I have several concerns with reference to the article by Giroux and colleagues (Giroux J, Wely TK, Oliver FK, et al. Low national breast cervical cancer-screening rates in American Indian and Alaska Native women with diabetes. *J Am Board Fam Pract* 2000;13:239-45). I have worked for the Sacramento Urban Indian Health Project for the last 13 years and am a great admirer of the frequent assessments of care that are done. They unquestionably promote high-quality care. There are a number of methodologic issues, however, with the Indian Health Service (IHS) Diabetes Audit that would tend to inflate the estimates of unscreened women cited in the article.

First, many women off the reservations get their diabetic care at Indian Health Service clinics and their gynecologic care elsewhere. In California the law requires that patients be free to self-refer for an annual gynecologic examination. More seriously, the IHS standards for cervical cancer screening differ markedly from those of other organizations. The IHS has a 12-month standard for Papanicolaou smears even in low-risk women because the rate of problems is very high. The advanced cancers, however, are not, at least in my experience, in the low-risk women who last had a Papanicolaou test 30 months ago, but are in the high-risk women who had one 5 years ago. Thus, many clinicians might consciously elect not to follow the IHS standard, especially since in many instances off-reservation patients are paying out of pocket for the reading. Also, the standard is 12 months, not annually. A woman who gets a Papanicolaou 13 months after her last one (and her insurance might not permit an interval of less than 12 months) falls out. Finally, the inclusion of an unknown number of women who have had a hysterectomy for benign disease and thus have no uterine cervix to sample renders their conclusions questionable.

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The above letter was referred to the authors of the article in question, who offer the following reply.

To the Editor: Dr. Samuelson correctly points out a limitation of this study. The Indian Health Service (IHS) Diabetes Audit does not exclude women who have had hysterectomies. The prevalence of surgical menopause in American Indian women aged 45 to 74 years varies by region. For North and South Dakota it is 29%.¹ The states in our study, North Dakota, South Dakota, Iowa, and Nebraska, are in the Aberdeen Area IHS (AAIHS). Some of the difference in cervical cancer screening in the IHS areas could partially be related to difference in hysterectomy rates. The IHS should consider excluding women who have hysterectomies for benign cause from calculation of Papanicolaou smear screening proportions.

Some patients, especially in urban areas, might obtain cancer screening from alternate sources, and this information might not be available at the time the charts are audited. In the four facilities in the AAIHS where we compared screening rates in diabetic and nondiabetic women, we carefully reviewed alternative sources of care and found that results of nearly all mammograms and Papanicolaou smears obtained by other providers were filed in the IHS records. So although we also were concerned that information on care received elsewhere might not be recorded in the IHS charts, our investigation showed that this was seldom a problem. There are differences in availability and access to care between IHS areas; therefore, as stated in the results section: "These findings are specific to the Aberdeen Area IHS and are not generalizable to IHS Areas." For other facilities serving American Indian or Alaska Native patients to know whether their audit of breast and cervical cancer screening rates are accurate, they would need to assess where else women were receiving treatment and evaluate whether this information was being recorded in their medical charts.

There are a variety of reasons why IHS women have not been screened, including that some providers might chose not to comply with the IHS standards. Because of high national American Indian and Alaska Native cervical cancer mortality rates, IHS standards currently require annual Papanicolaou smears from age 18 years or from onset of sexual activity. The IHS Diabetes Audit is designed to measure compliance with IHS guidelines. This IHS standard does differ from standards required by other organizations. Further studies should be conducted to reassess the rationale and advisability of continuing the IHS standard that requires annual Papanicolaou smears for all women, regardless of the number of normal Papanicolaou smear results and hysterectomy status.

The main purpose of the IHS Diabetes Audit is to provide information for action at the local level for quality improvement. The audit protocol established a method of selecting sample size and randomly picking medical charts. Although the IHS Diabetes Audit was not designed to ascertain regional breast and cervical cancer screening rates among American Indian or Alaska Native women, the data from the audit were the most accurate estimate of national screening rates at the time this study was done, and we believe the methodology of the audit is adequate for the purpose of this study.

In 1995, at the time of our study, American Indian and Alaska Native women in the AAIHS had the highest cervical cancer and second highest breast cancer mortality rates of all IHS areas.² Breast and cervical cancer screening for women in the AAIHS was limited. The states comprising the AAIHS were some of the last in the nation to implement the CDC Breast and Cervical Cancer Early Detection Program. This study was done in response to these high mortality rates and limited opportunities for screening in AAIHS. By publishing screening rates in women with diabetes, we hoped that providers in each area would assess their accuracy, promote systems that reduce the missed opportunities for cancer screening, and thereby reduce cancer mortality.

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References

1. Cowan LD, Go TO, Howard BV, et al. Parity, postmenopausal estrogen use, and cardiovascular disease risk factors in American Indian women: the Strong Heart Study. *J Womens Health* 1997;6:441-9.
2. Regional differences in Indian health. Washington, DC: Division of Program Statistics, Office of Planning, Evaluation and Legislation, Indian Health Service, Public Health Service, Department of Health and Human Services, 1994.

Future of Generalism

To the Editor: Edmund Pellegrino has written a thoughtful and troubling essay on the future of generalism in the 21st century.¹ His arguments are compelling. I believe, however, they represent a perspective not necessarily transferable to other industrialized nations. Further strengthening of the role of the generalist might well result from current initiatives toward health service integration.

An Australian health care experiment is beginning to show the benefits for such a strategy. The Divisions of General Practice Program has, since 1992, facilitated the development of 123 regionally based organizations consisting of between 50 and 400 family doctors. These Divisions of General Practice have allowed family doctors to form links with other practices, health providers, and the community to upgrade the quality and continuity of community health care.² After years of exclusion, general practitioners have been invited back into teaching hospitals, sharing care with specialists before, during, and after patient admission. Although there is much to be done and evaluations are incomplete, evidence is accumulating that the Divisional experiment is helping disparate health groups work together.³ Similar experiments have commenced in Great Britain, New Zealand, and Canada.

It seems bizarre that where these nations are taking active steps to strengthen the links between primary care and the wider health system, the reverse seems to be